

**BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA**

**In the Matter of the First Amended Accusation)**

**Against:**

**Michael S. Basch, M.D.**

**Physician's and Surgeon's  
Certificate No. A 62314**

**Respondent**

**Case No. 800-2015-014249**

**DECISION**

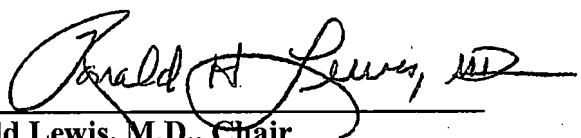
**The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.**

**This Decision shall become effective at 5:00 p.m. on August 21, 2019**

**IT IS SO ORDERED July 22, 2019**

**MEDICAL BOARD OF CALIFORNIA**

**By:**

  
\_\_\_\_\_  
**Ronald Lewis, M.D., Chair  
Panel A**

1 XAVIER BECERRA  
Attorney General of California  
2 ROBERT MCKIM BELL  
Supervising Deputy Attorney General  
3 COLLEEN M. MCGURRIN  
Deputy Attorney General  
4 State Bar Number 147250  
California Department of Justice  
5 300 South Spring Street, Suite 1702  
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7 *Attorneys for Complainant*

8  
9 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12  
13 In the Matter of the Accusation Against:

14 MICHAEL S. BASCH, M.D.  
41593 Winchester Road, Suite 101  
15 Temecula, California 92590

16 Physician's and Surgeon's Certificate No. A  
62314

17 Respondent.  
18

Case No. 800-2015-014249

OAH No. 2018050994

**STIPULATED SETTLEMENT AND  
DISCIPLINARY ORDER**

19 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-  
20 entitled proceedings that the following matters are true:

21 **PARTIES**

22 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board  
23 of California (Board). She brought this action solely in her official capacity and is represented in  
24 this matter by Xavier Becerra, Attorney General of the State of California, by Colleen M.  
25 McGurrin, Deputy Attorney General.

26 2. MICHAEL S. BASCH, M.D. (Respondent) is represented in this proceeding by  
27 attorney Raymond J. McMahon, Esq. of Doyle Schafer McMahon, LLP, whose address is: 5440  
28 Trabuco Road, Irvine, California 92620.

3. On or about May 9, 1997, the Board issued Physician's and Surgeon's Certificate No. A 62314 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-014249, and will expire on April 30, 2020, unless renewed.

## JURISDICTION

4. The First Amended Accusation No. 800-2015-014249 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on October 18, 2018. Respondent timely filed his Notice of Defense contesting the First Amended Accusation.

5. A copy of First Amended Accusation No. 800-2015-014249 is attached as exhibit A and incorporated herein by reference.

## ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2015-014249. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent freely, voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

## CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2015-014249, if proven at a hearing, constitute cause for imposing discipline

1 upon his Physician's and Surgeon's Certificate.

2 10. For the purpose of resolving the First Amended Accusation without the expense and  
3 uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could  
4 establish a prima facie factual basis for the charges in the First Amended Accusation, and that  
5 Respondent hereby gives up his right to contest those charges.

6 11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to  
7 discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the  
8 Disciplinary Order below.

9 CONTINGENCY

10 12. This stipulation shall be subject to approval by the Medical Board of California.  
11 Respondent understands and agrees that counsel for Complainant and the staff of the Medical  
12 Board of California may communicate directly with the Board regarding this stipulation and  
13 settlement, without notice to or participation by Respondent or his counsel. By signing the  
14 stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek  
15 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails  
16 to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary  
17 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal  
18 action between the parties, and the Board shall not be disqualified from further action by having  
19 considered this matter.

20 13. The parties understand and agree that Portable Document Format (PDF) and facsimile  
21 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile  
22 signatures thereto, shall have the same force and effect as the originals.

23 14. In consideration of the foregoing admissions and stipulations, the parties agree that  
24 the Board may, without further notice or formal proceeding, issue and enter the following  
25 Disciplinary Order:

26 ///

27 ///

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1 **DISCIPLINARY ORDER**

2 **A. PUBLIC REPRIMAND**

3 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 62314 issued  
4 to Respondent MICHAEL S. BASCH, M.D., shall be and is hereby Publicly Reprimanded  
5 pursuant to Business and Professions Code section 2227, subdivision (a)(4). This Public  
6 Reprimand, which is issued in connection with Respondent's care and treatment of Patient A as  
7 set forth in First Amended Accusation No. 800-2015-014249, is as follows:

8 1. On or about April 30, 2013 through May 7, 2013, in caring for Patient A, you failed  
9 to perform a formal and complete cognitive assessment of the patient's functional capacity to  
10 screen for and adequately support your diagnosis of dementia in violation of Business and  
11 Professions Code section 2234, subdivision (c).

12 **B. EDUCATION COURSE.** Within 60 calendar days of the effective date of this  
13 Decision, Respondent shall submit to the Board or its designee for its prior approval educational  
14 program(s) or course(s), which shall not be less than 20 hours. The educational program(s) or  
15 course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be  
16 Category I certified. The educational program(s) or course(s) shall be at Respondent's expense  
17 and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of  
18 licensure. Following the completion of each course, the Board or its designee may administer an  
19 examination to test Respondent's knowledge of the course. Respondent shall provide proof of  
20 attendance for 45 hours of CME of which 20 hours were in satisfaction of this condition.

21 **C. MEDICAL RECORD KEEPING COURSE.** Within 60 calendar days of the  
22 effective date of this Decision, Respondent shall enroll in a course in medical record keeping  
23 approved in advance by the Board or its designee. Respondent shall provide the approved course  
24 provider with any information and documents that the approved course provider may deem  
25 pertinent. Respondent shall participate in and successfully complete the classroom component of  
26 the course not later than six (6) months after Respondent's initial enrollment. Respondent shall  
27 successfully complete any other component of the course within one (1) year of enrollment. The  
28 medical record keeping course shall be at Respondent's expense and shall be in addition to both

1 the Continuing Medical Education (CME) requirements for renewal of licensure and the  
2 Education Course(s) required by Condition B above.

3 A medical record keeping course taken after the acts that gave rise to the charges in the  
4 First Amended Accusation, but prior to the effective date of the Decision may, in the sole  
5 discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the  
6 course would have been approved by the Board or its designee had the course been taken after the  
7 effective date of this Decision.

8 Respondent shall submit a certification of successful completion to the Board or its  
9 designee not later than 15 calendar days after successfully completing the course, or not later than  
10 15 calendar days after the effective date of the Decision, whichever is later.

11 **D. PRESCRIBING PRACTICES COURSE.** Within 60 calendar days of the  
12 effective date of this Decision, Respondent shall enroll in a course in prescribing practices  
13 approved in advance by the Board or its designee. Respondent shall provide the approved course  
14 provider with any information and documents that the approved course provider may deem  
15 pertinent. Respondent shall participate in and successfully complete the classroom component of  
16 the course not later than six (6) months after Respondent's initial enrollment. Respondent shall  
17 successfully complete any other component of the course within one (1) year of enrollment. The  
18 prescribing practices course shall be at Respondent's expense and shall be in addition to the  
19 Continuing Medical Education (CME) requirements for renewal of licensure.

20 A prescribing practices course taken after the acts that gave rise to the charges in the  
21 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board  
22 or its designee, be accepted towards the fulfillment of this condition if the course would have  
23 been approved by the Board or its designee had the course been taken after the effective date of  
24 this Decision.

25 Respondent shall submit a certification of successful completion to the Board or its  
26 designee not later than 15 calendar days after successfully completing the course, or not later than  
27 15 calendar days after the effective date of the Decision, whichever is later.

28 ///

1 ACCEPTANCE

2 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully  
3 discussed it with my attorney, Raymond J. McMahon, Esq. I understand the stipulation and the  
4 effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated  
5 Settlement and Disciplinary Order freely, voluntarily, knowingly, and intelligently, and agree to  
6 be bound by the Decision and Order of the Medical Board of California.

7 DATED: 5/19/2019

8 MICHAEL S. BASCH, M.D.  
9 Respondent

10 I have read and fully discussed with Respondent MICHAEL S. BASCH, M.D. the terms  
11 and conditions and other matters contained in the above Stipulated Settlement and Disciplinary  
12 Order. I approve its form and content.

13 DATED: May 20, 2019

14 RAYMOND J. MCMAHON, ESQ.  
15 Attorney for Respondent

16 ENDORSEMENT

17 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully  
18 submitted for consideration by the Medical Board of California.

19 Dated: 5/20/19

20 Respectfully submitted,

21 XAVIER BECERRA  
22 Attorney General of California  
23 ROBERT MCKIM BELI,  
24 Supervising Deputy Attorney General

25 COLLEEN M. MCGURRIN  
26 Deputy Attorney General  
27 Attorneys for Complainant

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**Exhibit A**

**First Amended Accusation No. 800-2015-014249**

1 XAVIER BÉCERRA  
Attorney General of California  
2 JUDITH T. ALVARADO  
Supervising Deputy Attorney General  
3 NICHOLAS B.C. SCHULTZ  
Deputy Attorney General  
4 State Bar No. 302151  
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5 300 South Spring Street, Suite 1702  
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*Attorneys for Complainant*

FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO October 18, 2018  
BY K. Voong ANALYST

8  
9 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
**DEPARTMENT OF CONSUMER AFFAIRS**  
10 **STATE OF CALIFORNIA**

11 In the Matter of the First Amended Accusation  
12 Against:

Case No. 800-2015-014249

**FIRST AMENDED ACCUSATION**

13 MICHAEL S. BASCH, M.D.  
41593 Winchester Road, # 101  
14 Temecula, California 92590

15 Physician's and Surgeon's Certificate  
No. A 62314,

16 Respondent.  
17

18 Complainant alleges:

19 **PARTIES**

20 1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in  
21 her official capacity as the Executive Director of the Medical Board of California, Department of  
22 Consumer Affairs (Board).

23 2. On or about May 9, 1997, the Board issued Physician's and Surgeon's Certificate  
24 Number A 62314 to Michael S. Basch, M.D. (Respondent). That license was in full force and  
25 effect at all times relevant to the charges brought herein and will expire on April 30, 2019, unless  
26 renewed.

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4. Section 2001.1 of the Code states:

5. Section 2227 of the Code states:

"(1) Have his or her license revoked upon order of the board.

“(3) Be placed on probation and be required to pay the costs of probation monitoring upon of the board.

“(5) Have any other action taken in relation to discipline as part of an order of probation, as board or an administrative law judge may deem proper.

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1 existing law, is deemed public, and shall be made available to the public by the board pursuant to  
2 Section 803.1.”

3 6. Section 2234 of the Code, states:

4 “The board shall take action against any licensee who is charged with unprofessional  
5 conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not  
6 limited to, the following:

7 “(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the  
8 violation of, or conspiring to violate any provision of this chapter.

9 “...

10 “(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or  
11 omissions. An initial negligent act or omission followed by a separate and distinct departure from  
12 the applicable standard of care shall constitute repeated negligent acts.

13 “(1) An initial negligent diagnosis followed by an act or omission medically appropriate  
14 for that negligent diagnosis of the patient shall constitute a single negligent act.

15 “(2) When the standard of care requires a change in the diagnosis, act, or omission that  
16 constitutes the negligent act described in paragraph (1), including, but not limited to, a  
17 reevaluation of the diagnosis or a change in treatment, and the licensee’s conduct departs from the  
18 applicable standard of care, each departure constitutes a separate and distinct breach of the  
19 standard of care.

20 “...”

21 7. Section 2266 of the Code, states:

22 “The failure of a physician and surgeon to maintain adequate and accurate records relating  
23 to the provision of services to their patients constitutes unprofessional conduct.”

24 **FACTUAL SUMMARY**

25 8. Between March 2008 and August 2013, Respondent worked as a physician at Talia  
26 Medical Group, which is located at 41593 Winchester Road, #101, in Temecula, California.

27 ///

28 ///

1 Patient A

2 9. Respondent first saw Patient A<sup>1</sup> on or about April 30, 2013. At the time of that visit,  
3 Patient A was a 92-year-old woman with a medical history of heart disease, hypertension,  
4 osteoporosis, gouty arthritis, and osteoarthritis. Prior to this initial meeting, Patient A's daughter  
5 informed Respondent that Patient A suffered from dementia and bipolar illness. Patient A's  
6 daughter requested hospice care<sup>2</sup> for her mother. Patient A's daughter also reported that Patient  
7 A was severely dependent on pain medications. During this initial visit, Respondent performed a  
8 detailed review of Patient A's systems and an extensive physical examination. Patient A's body  
9 mass index was 17.54. There were no particular symptoms elicited and the physical examination  
10 revealed no abnormalities. Importantly, there were no abnormal psychiatric symptoms reported  
11 in Respondent's chart notes. Patient A was alert and oriented. She denied any unusual anxiety or  
12 depression. Respondent ordered laboratory studies and reviewed Patient A's current medications.

13 10. Respondent next saw Patient A on or about May 7, 2013. Respondent reviewed  
14 Patient A's laboratory results and renewed her pre-existing prescription medications initially  
15 prescribed by her primary care physician(s). Patient A's laboratory studies were unremarkable as  
16 she had normal hemoglobin, albumin, and renal function. Patient A's body mass index was 17.36  
17 at this visit. Patient A denied any fatigue, weakness, or shortness of breath. Again, Respondent  
18 denied any unusual anxiety or depression symptoms. Patient A was alert and oriented.  
19 Importantly, Respondent did not perform a functional capacity assessment during this visit to  
20 determine if Patient A was able to perform her simple activities of daily living.

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23  
24 <sup>1</sup> The patient herein is referred to as Patient A to protect her privacy.

25 <sup>2</sup> Hospice care is a model of medical care that is designed to provide comprehensive  
26 interdisciplinary palliative care for patients with life-limiting illness and a prognosis of six (6) months or  
27 less if the disease follows its natural course. Hospice care is appropriate for patients entering the last  
28 weeks or months of life, and when patients or their families decide to forego further curative therapies.  
Hospice care can also be offered to patients with declining functionality who are also suffering from an  
end stage non-cancer diagnosis such as heart attack, chronic obstructive pulmonary disease, cirrhosis,  
renal failure, dementia, and failure to thrive.

1 11. Respondent diagnosed Patient A with failure to thrive.<sup>3</sup> However, Respondent did  
2 not complete a detailed history of the patient focusing on timing and symptoms of frailty,  
3 disability, and neuropsychiatric impairment. Respondent failed to explore underlying weight loss  
4 and feeding factors such as dysphagia, diarrhea, and nausea. Respondent did not document or  
5 assess Patient A's ability to perform activities of daily living or her living situation. Moreover,  
6 Respondent did not conduct a mental status exam or geriatric depression scale to evaluate Patient  
7 A for dementia or depression, which are often a part of failure to thrive syndrome. Finally,  
8 Respondent did not order additional laboratory testing or radiologic imaging to exclude any  
9 chronic illnesses and cancer diagnoses.

10 12. Respondent also diagnosed Patient A as having dementia<sup>4</sup> with mental incapacity on  
11 or about May 7, 2013. However, Respondent did not utilize cognitive testing to screen and  
12 diagnose dementia illnesses, such as the Mini-Mental Status Exam (MMSE), the Cognitive  
13 Abilities Screening Instrument (CASI), or the Montreal Cognitive Assessment (MOCA).  
14 Similarly, Respondent did not order brain scans or additional laboratory testing to exclude the  
15 reversible causes of dementia. Respondent also did not refer Patient A for in-depth  
16 neuropsychological testing administered by a psychiatrist. In total, Respondent did not complete  
17 any formal cognitive testing or assessment of Patient A's functional capacity.

18 ///

19 <sup>3</sup> Failure to thrive is a syndrome of global decline in older adults that often manifests in the form  
20 of weight loss (greater than five percent in a twelve-month period), decreased appetite, poor nutrition,  
21 inactivity, and physical exhaustion or weakness. This syndrome occurs in older adults as physical frailty  
22 worsens and is frequently compounded by cognitive impairment and functional disability. Failure to  
23 thrive is a nonspecific manifestation of an underlying physical, mental, or psychosocial condition. Patients  
often experience difficulty in completing self-care and independent living tasks. Delirium, depression, and  
dementia are the most common conditions impairing cognitive status in older adults and, therefore, they  
are the leading causes of failure to thrive in the geriatric population.

24 <sup>4</sup> Dementia is a decline and loss of memory, reasoning, judgment, language, and behavior that are  
25 not part of the normal aging process. It progressively worsens over time and is irreversible. As the  
26 disease progresses, patients will often suffer from mood swings, personality changes, paranoia, poor  
27 judgment, and an inability to learn new information. In the later stages of dementia, a patient will have  
28 complete loss of short-term and long-term memories. Hallucinations often manifest in late stage dementia.  
Consequently, dementia patients are dependent upon others for normal daily activities such as bathing,  
dressing, feeding, and personal hygiene. The risk of malnourishment can lead to frequent infections and  
mechanical falls that are dangerous. Alzheimer's dementia is responsible for approximately fifty (50) to  
seventy (70) percent of dementia cases. There is no known cure for dementia and the medial duration of  
survival is about eight (8) years from the time of diagnosis.

1           13. After her second and last visit with Respondent, and after knowing Patient A for only  
2 about one week, Respondent accepted Patient A into a local hospice program based on the  
3 diagnoses of dementia with declining functional status and failure to thrive syndrome. However,  
4 Respondent's chart notes did not reflect a terminal prognosis of six months or less for Patient A.  
5 Rather, Patient A's cardiopulmonary, liver, and kidney functions were not end stage. She had no  
6 documented active cancers.

7           14. Although Patient A did not have more clinical visits with Respondent after May 7,  
8 2013, she continued to be under his medical care in the hospice program for the next several  
9 months. Starting on or about May 13, 2013, Respondent prescribed 10 milligram tablets of  
10 hydrocodone, 0.5 milligram tablets of lorazepam, and 20 milligram tablets of morphine to Patient  
11 A. These medications were filled by Advance Care Pharmacy while she remained in hospice  
12 care. Patient A was also treated with antipsychotic medication and psychiatric care at  
13 Respondent's direction.

14           15. In July 2014, Patient A underwent an independent psychological and mental capacity  
15 assessment, but not at the request or direction of Respondent. The psychiatrist found that Patient  
16 A was capable of decision making with regards to her health, finances, estate planning, and her  
17 last will and testament. According to this assessment, Patient A was functioning at a high level of  
18 cognitive ability given her age.

19           16. Patient A lived for approximately three more years after she was placed in the local  
20 hospice program pursuant to Respondent's diagnoses of dementia and failure to thrive. Patient A  
21 ultimately passed away in June 2016 from complications of skin cancer treatment.

22 Patient B

23           17. Respondent first saw Patient B<sup>5</sup> on or about March 31, 2008. At the time of this  
24 initial visit, Patient B was a 42-year-old woman with multiple medical conditions including breast  
25 cancer, carpal tunnel syndrome, epilepsy, scoliosis, chronic lower back pain, and leg surgeries.  
26 She also had an extensive psychiatric history including depression, generalized anxiety,  
27 schizophrenia, and bipolar disorder. Patient B was in a drug detoxification program in 2009 for

28           <sup>5</sup> The patient herein is referred to as Patient B to protect her privacy.

1 oxycodone abuse. Patient B started seeing Respondent for primary care and pain management in  
2 2008. She continued as a patient under Respondent's care until her death on January 12, 2012.

3 18. During this period of time, Respondent routinely prescribed to Patient B a Fentanyl  
4 transdermal patch<sup>6</sup> at 50 micrograms per hour for chronic pain. The dosage of the Fentanyl  
5 transdermal patch was eventually increased to 75 micrograms per hour in 2010. While  
6 Respondent was prescribing the Fentanyl transdermal patch to Patient B, she was also receiving  
7 prescriptions for benzodiazepines<sup>7</sup> from her mental health and neurology providers on a regular  
8 basis. Respondent was aware of Patient B's use of benzodiazepine and he continued to prescribe  
9 the Fentanyl transdermal patch to Patient B through January 2012, thereby increasing her risk for  
10 accidental overdose to the combination of the drugs. Respondent did not utilize a less potent or  
11 shorter acting opiate medication during this period of time.

12 19. Between March 2008 and January 2012, Respondent did not utilize a  
13 multidisciplinary approach to managing Patient B's chronic pain. Respondent did not utilize  
14 nonsteroidal anti-inflammatory drugs (NSAIDs), tricyclics, muscle relaxants, yoga, or physical  
15 therapy as alternatives to reduce the potential for Patient B's dependency on opiates. Similarly,  
16 Respondent did not refer Patient B for cognitive behavioral therapy as part of the pain  
17 management protocol.

18 20. Patient B's last documented clinical visit with the Respondent took place on March 8,  
19 2011. However, Respondent continued to prescribe the Fentanyl transdermal patch to Patient B  
20 over the following nine-month period. Patient B received her last Fentanyl patch prescription  
21

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22 <sup>6</sup> A Fentanyl transdermal patch, commonly sold under the brand name "Duragesic," is a high  
23 potency and long acting drug that is used to help relieve severe ongoing pain for patients. Fentanyl is  
24 classified as a Schedule II substance under the Controlled Substance Act and is known for its high  
25 potential for abuse, with use potentially leading to severe psychological or physical dependence. Fentanyl  
26 belongs to a class of drugs known as opiod (narcotic) analgesics. It works in the human brain to change  
27 how the body feels and responds to pain. Fentanyl may be habit forming, especially with prolonged use.

28 <sup>7</sup> Benzodiazepines are a class of psychoactive drugs that enhance the effect of the neurotransmitter  
gamma-aminobutyric acid (GABA) at the GABA receptor, resulting in sedative, hypnotic (sleep-  
inducing), anxiolytic (anti-anxiety), anticonvulsant, and muscle relaxant properties. Benzodiazepines are  
classified as a Schedule IV substance under the Controlled Substance Act. When combined with other  
central nervous system (CNS) depressants such as alcoholic drinks and opioids, the potential for toxicity  
and fatal overdose increases for the patient.

1 prior to her death on January 12, 2012. Respondent's medical records do not note any visits or  
2 consultations with Patient B after March 8, 2011.

3 21. Respondent's medical records for Patient B failed to properly document her elevated  
4 opioid risks including her history of depression, schizophrenia, bipolar disorder, and past  
5 oxycodone abuse. In fact, Respondent's medical records for Patient B were deficient in detailing  
6 the intensity pain scale, the potential side effects of the opiate<sup>8</sup> medications, the functional goals  
7 of pain management, and urine drug testing results. Moreover, Patient B continued to experience  
8 chronic pain despite notations in the medical record that she had no musculoskeletal pain.

9 22. Patient B was found unresponsive in her mother's home on January 12, 2012. Patient  
10 B was pronounced dead at approximately 8:25 a.m. Patient B was wearing a Fentanyl  
11 transdermal patch when examined by the Riverside County Sheriff-Coroner's Office. Toxicology  
12 testing was conducted which confirmed the presence of Fentanyl in Patient B's system at the time  
13 of her death. Patient B's cause of death was subsequently identified as Acute Fentanyl  
14 Intoxication by the Riverside County Sheriff-Coroner's Office.

#### 15 STANDARD OF CARE

16 23. **Diagnosis of Dementia.** The community standard of care in medical practice in the  
17 State of California is to use cognitive testing to screen and diagnose dementia illnesses in a  
18 patient. A physician must utilize one of several reliable tests such as the Mini-Mental Status  
19 Exam (MMSE), the Cognitive Abilities Screening Instrument (CASI), or the Montreal Cognitive  
20 Assessment (MOCA). Furthermore, a physician should consider ordering brain scans and  
21 laboratory testing to exclude reversible causes of dementia. When diagnosis is not clear based  
22 upon the screening tests, laboratory testing, and brain scans, then a physician should refer the  
23 patient for in-depth neuropsychological testing administered by a psychiatrist.

24 ///

25 <sup>8</sup> Opioids are narcotic medications that act on opioid receptors in the human body to produce  
26 morphine-like effects. These drugs are primarily used for pain relief. Side effects of opioids may include  
27 itchiness, sedation, nausea, respiratory depression, constipation, and euphoria. Tolerance and dependence  
28 will develop with continuous use of opiates, requiring increasing doses and leading to a withdrawal  
syndrome upon abrupt discontinuation. The euphoria attracts recreational use and frequent, escalating  
recreational use of opioids typically results in addiction. An overdose or concurrent use with other  
depressant drugs commonly results in death from respiratory depression.

1       **24. Diagnosis of Failure to Thrive.** The community standard of care in medical practice  
2 in the State of California is to conduct a physical examination of the patient, as well as a detailed  
3 history focused on timing and symptoms of frailty, disability, and neuropsychiatric impairment  
4 before making the diagnosis of failure to thrive. A physician must explore other factors related to  
5 weight loss and feeding such as dysphagia, diarrhea, and nausea. Nutritional supplements and/or  
6 a speech therapy evaluation can be done to assess for any swallowing pathology that can be  
7 corrected. The physician's physical examination should assess the patient's living situation and  
8 his/her functional ability to perform activities of daily living, which may later require a social  
9 worker visit to the patient's home. Physical and occupational therapy can be offered to improve  
10 the patient's functional impairments. Moreover, a physician should conduct a mental status exam  
11 or geriatric depression scale to evaluate for dementia or depression, which are often a part of  
12 failure to thrive syndrome. If appropriate, a physician can prescribe anti-depressants and anti-  
13 dementia medications along with psychotherapy. Finally, limited laboratory testing and  
14 radiologic imaging should be done to exclude any chronic illnesses and cancer diagnoses.

15       **25. Eligibility for Hospice Care.** The community standard of care in medical practice in  
16 the State of California is to offer hospice care to terminally ill cancer patients who are suffering  
17 from cancer pains and are not expected to survive more than six months. However, hospice care  
18 can also be offered to patients with declining functionality who are suffering from end stage non-  
19 cancerous diagnoses such as heart failure, chronic obstructive pulmonary disease, cirrhosis, renal  
20 failure, dementia, and geriatric failure to thrive. Ultimately, hospice is appropriate for patients  
21 that are entering the last weeks to months of life when the patient and their families decide to  
22 forego further life-prolonging therapies or treatments.

23       **26. Monitoring and Reassessment of Chronic Opiate Pain Management.** The  
24 community standard of care in medical practice in the State of California is to monitor a patient's  
25 progress while using opioid medication for both benefit and harm, including the patient's level of  
26 pain, function, analgesia, activities of daily living, quality of life, adverse side effects, and  
27 aberrant behaviors. The patient's risk of drug addiction and aberrancy should also be assessed to  
28 mitigate potentially adverse consequences of opiate therapy. This involves performing a

1 psychological evaluation assessing risks of addictive behaviors and referral to a psychiatrist, if  
2 warranted, for ongoing treatment, as well as monitoring with regular urine drug testing and  
3 consultations with the state prescription drug monitoring program. A patient whose pain is  
4 adequately controlled at a safe dosage of opiate therapy must be monitored on a regular basis  
5 every one to three months by her physician in order to determine if the pain medication is meeting  
6 the patient's goals of improved pain and functional status.

7       **27. Concurrent Prescriptions for Benzodiazepine and Opiate Medications.** The  
8 community standard of care in medical practice in the State of California is for physicians to  
9 strongly avoid prescribing both narcotic and benzodiazepine medications to a patient because the  
10 risks to the patient outweigh the benefits. Benzodiazepine and opiate medications both cause  
11 central nervous system depression and can decrease respiratory drive. Concurrent use of both  
12 medications by a patient likely places the patient at greater risk for a potentially fatal overdose.  
13 When confronted with a patient on both medications, a physician should taper the patient off of  
14 the opiate medication first unless the patient would prefer to continue opiate therapy, in which  
15 case the physician must taper off the benzodiazepine medication. A physician should also consult  
16 with psychiatry staff for cognitive behavior therapy.

17       **28. Proper Maintenance of Medical Records.** The community standard of care in  
18 medical practice in the State of California is for a physician to maintain accurate and adequate  
19 medical records. A physician treating a patient who is prescribed opiate medications should  
20 maintain a medical record that includes documentation of medical history, results of physical  
21 examination, and all the necessary laboratory and radiologic tests. Discussion of patient consent  
22 for using controlled substances and pain management agreements should also be included in the  
23 medical record. A physician's medical record for a patient should reflect all treatment provided,  
24 including all medications prescribed and any consultations. The results of ongoing monitoring of  
25 patient progress or lack of progress in pain management, including urine drug testing, and  
26 functional improvement should be documented by the physician, as well as steps taken in  
27 response to any aberrant behaviors in opiate usage.

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1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 29. Respondent's license is subject to disciplinary action under Section 2234, subdivision  
4 (c) of the Code, in that Respondent committed repeated negligent acts during his care and  
5 treatment of Patients A and B. The circumstances are as follows:

6 30. Complainant refers to and, by this reference, incorporates paragraphs 8 through 28  
7 above, as though fully set forth herein.

8 31. The following acts and omissions, considered individually and collectively, constitute  
9 repeated negligent acts in Respondent's practice as a physician and surgeon:

10 A. Failing to perform a formal and complete cognitive assessment of Patient A's  
11 functional capacity to screen for and adequately support Respondent's diagnosis of dementia.

12 B. Diagnosing Patient A with failure to thrive despite laboratory findings and  
13 observations that did not support Respondent's diagnosis, as well as failing to explore other  
14 causes for Patient A's slightly below normal body mass index.

15 C. Accepting Patient A into the hospice program when there were no signs or symptoms  
16 of end state dementia or geriatric failure to thrive syndrome.

17 D. Lack of proper monitoring and reassessment of Patient B's chronic opiate pain  
18 management, including opioid risk and clinical pain, while prescribing a Fentanyl transdermal  
19 patch.

20 E. Prescribing an opiate medication to Patient B who was concurrently using a  
21 benzodiazepine medication prescribed by her other health care providers.

22 F. Failing to maintain adequate and accurate medical records with regards to the care  
23 and treatment provided to Patient B.

24 **SECOND CAUSE FOR DISCIPLINE**

25 **(Inadequate and/or Inaccurate Medical Record Keeping)**

26 32. By reason of the facts set forth in paragraphs 17 through 22 above, Respondent's  
27 license is further subject to disciplinary action under Section 2266 of the Code, in that

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1 Respondent failed to maintain adequate and accurate records relating to his provision of services  
2 to Patient B.

3 33. Respondent's acts and/or omissions as set forth in paragraphs 17 through 22 above,  
4 whether proven individually, jointly, or in any combination thereof, constitute Respondent's  
5 failure to maintain adequate and accurate records relating to his provision of services to Patient B,  
6 pursuant to Section 2266 of the Code.

7 **THIRD CAUSE FOR DISCIPLINE**

8 **(Unprofessional Conduct)**

9 34. By reason of the facts set forth in paragraph 8 through 28 above, Respondent is  
10 subject to disciplinary action under Section 2234, subdivision (a) of the Code, in that Respondent  
11 has engaged in unprofessional conduct based upon repeated negligent acts in the care and  
12 treatment of Patients A and B, and his failure to maintain adequate or accurate medical records  
13 concerning the care and treatment of Patient B.

14 35. Respondent's acts and/or omissions as set forth in paragraphs 8 through 28 above,  
15 whether proven individually, jointly, or in any combination thereof, constitute Respondent's  
16 unprofessional conduct based upon repeated negligent acts in the care and treatment of Patients A  
17 and B, and his failure to maintain adequate or accurate medical records concerning the care and  
18 treatment of Patient B, pursuant to Section 2234, subdivision (a) of the Code.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 62314 issued to Michael S. Basch, M.D.;
2. Revoking, suspending or denying approval of his authority to supervise physician assistants pursuant to Section 3527 of the Code, and advanced practice nurses;
3. If placed on probation, ordering Michael S. Basch, M.D. to pay the Board the costs of probation monitoring; and
4. Taking such other and further action as deemed necessary and proper.

DATED: October 18, 2018

  
KIMBERLY KIRCHMEYER  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
Complainant

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